November 4, 2020

Wendy MacLeod, MD
National Medical Director
UnitedHealthcare
9900 Bren Road East
Minnetonka, MN 55343

Jaime E. Murillo, MD, FACC, FASE
Senior Medical Director
UnitedHealthcare
9900 Bren Road East
Minnetonka, MN 55343

Lewis G. Sandy, MD, FACP
Executive Vice President
Clinical Advancement
UnitedHealth
9900 Bren Road East
Minnetonka, MN 55343

Dear Dr. MacLeod, Dr. Murillo and Dr. Sandy:

On behalf of the American Society of Nuclear Cardiology (ASNC), we are writing with regard to UnitedHealthcare's (UHC) May 2020 Network Bulletin which included a reimbursement update for Coronary Computed Tomography Angiography (CCTA) for diagnosing and evaluating coronary artery disease (CAD).

> *Coronary CTA Reimbursement Update*
>
> *Effective April 1, 2020, we will reimburse for Coronary CT Angiograms when ordered to evaluate stable chest pain in members with low and intermediate risk for coronary artery disease (CAD) as first-line testing (CCTA-First). Computed tomographic angiography (CTA) is expected to replace the need for other functional stress testing in this population.*
>
> *The following are considered functional stress tests:*
>
> - *Nuclear Stress*
> - *Stress Echocardiogram*
> - *PET Stress*
>
> *The following CPT® codes will be reimbursed for suspected CAD:*
>
> - *75574: Computed tomographic angiography (CTA)*
> - *0501T – 0504T: Fractional Flow Reserve CT (FFRct)*

ASNC is a 4,500-member professional medical society, which provides a variety of continuing medical education programs related to nuclear cardiology and cardiovascular computed tomography, develops standards and guidelines for training and practice, promotes accreditation and certification within the nuclear cardiology field, and is a major advocate for furthering research and excellence in nuclear cardiology and cardiovascular computed tomography.

Following release of this reimbursement update, ASNC and the American College of Cardiology expressed concern the revised coverage document could be interpreted as restricting access to functional stress testing. In May, ASNC received assurances from UHC leadership the policy changes would support CTA coverage where it is appropriate without mandating practice changes where other forms of stress testing are appropriate for the patient.

Despite those assurances, UHC maintains the position that CTA is expected to replace the need for other functional stress testing to evaluate stable chest pain in individuals with low and intermediate risk for CAD. In fact, UHC's CCTA-First policy in this patient population ignores the well-established role of functional imaging as a first-line test in populations when CTA cannot or should not be performed.

There are multiple real-world studies of myocardial perfusion imaging involving thousands of patients which demonstrate powerful risk stratification and effective treatment options based on the severity of ischemia. Despite the advent of CCTA and CT-FFR, this technique has failed to demonstrate, in large real-world studies, that a strategy of anatomy-first is more effective than functional imaging. CCT-FFR remains a Category III CPT code, and it is inappropriate that it should replace well-established functional imaging as a first-line test.

The cornerstone of the patient-physician relationship is based on shared decision-making; that is, to make the decision for the right test or treatment at the right time based on sound clinical judgement and honest discussions with patients about risks and benefits. UHC's policy threatens that relationship. As written, the policy misleads providers to believe CTA is in all cases a clinically better test, an implication that could spill over into other patient populations.

Heart disease is the number one cause of death in America. Great strides, however, have been made in the last 20 years to reduce the morbidity and mortality of CAD. Appropriate use criteria exist for most cardiac tests and treatments. When more than one test or procedure is considered appropriate, they are always given equal weight. Such is the case with physiologic and anatomic testing for CAD.

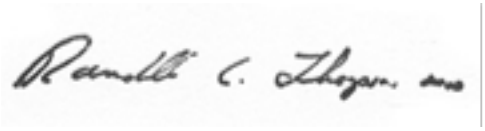
Functional noninvasive imaging at present is the standard of care for the management of stable ischemic heart disease. UHC's revised policy will provide automatic approval for CTA, while physicians who insist on a stress test must go through the prior authorization process and unnecessary delays in patient care.

Provider education is a powerful mechanism to improve appropriateness of cardiac imaging and ASNC continues to stand ready to partner with UHC in this regard. The important role of functional imaging in diagnosing CAD must be recognized for use in all indications without the preferential suggestion of CTA. We therefore ask that UHC's policy be amended to reflect a similar process for obtaining permission for either a functional test (SPECT, PET, STRESS echo or stress CMR) or CTA.

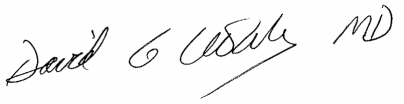
We respectfully request an opportunity to discuss our concerns with you, as we seek to assure that patients covered under UHC have access to the best possible cardiovascular care. To schedule a conversation, please contact Camille Bonta at (202) 320-3658 or cbonta@summithealthconsulting.com.

Sincerely,

Sharmila Dorbala, MD
President
American Society of Nuclear Cardiology



Randall Thompson, MD
President-Elect
American Society of Nuclear Cardiology



David Wolinsky, MD
Chair, Health Policy Committee
American Society of Nuclear Cardiology